Employers Who Have 50 or More Employees Using Public Health Assistance

A Report by the Executive Office of Health and Human Services
Division of Health Care Finance and Policy
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I. INTRODUCTION

Section 304 of Chapter 149 of the Acts of 2004 requires the Executive Office of Health and Human Services to produce a list of employers who have 50 or more employees using public health assistance each year. This brief report provides the results of the first annual analysis completed by the Division of Health Care Finance and Policy (DHCFP) in collaboration with staff from the Office of Medicaid. The legislation specified that the report include the following information for each employer:

1. Name and address
2. Number of public health access program beneficiaries who are employees of employer
3. Number of public health access program beneficiaries who are spouses or dependents
4. Whether the employer offers health benefits to its employees
5. Cost to Commonwealth of providing public health program benefits to employees and dependents.

For the purposes of this report, "public health assistance" includes MassHealth and the Uncompensated Care Pool (UCP). This report provides background information from surveys conducted by the DHCFP on the uninsured and on employer trends regarding health insurance, a description of the methodology used to develop the attached list of employers who have 50 or more employees using public health assistance, a discussion of the limitations of the analysis, and the results.

II. BACKGROUND

A Massachusetts household survey conducted in 2004 found that sixty-eight percent of the uninsured are employed and forty-five percent of the uninsured work full-time (35 hours or more). Most people in Massachusetts, as is true throughout the United States, receive their health insurance benefits through their employer. A 2003 employer survey conducted by the DHCFP in Massachusetts found that nearly all firms (98%) with more than 50 employees offer health insurance. Although large firms are more likely to offer health insurance to their employees than small firms, reasonably high offer rates (86.6%) were also found among firms with 25 to 50 employees, as well as among firms with 10 to 25 employees (89.1%).

While the offer rates are relatively high among all employers, the rate of uninsured workers among firms with 50 or fewer employees is much higher (20.8%) than the uninsured rate among larger firms (4.6%). However, many of the uninsured work for firms with more than 50 employees (40.2% of the working uninsured) because of the greater number of people employed by large firms.

There are a number of reasons why someone working for an employer who offers health insurance is not insured through that employer. Many employees report cost as the primary factor in declining offered coverage. Other reasons include: not being eligible for insurance due to part-time status, being newly employed and not yet eligible for insurance, health insurance offered by employer not viewed as a good value by the employee, the availability of insurance through a spouse, and the availability of coverage through safety-net care programs.

It's easy to see why employees mention cost as a factor. Although premiums for individuals remain well subsidized by most employers (the average subsidy was 73% in 2003) resulting in a reasonable price and good value for most working people at approximately $87/month, family plans have become very expensive (the average employee premium was $245/month in 2003) particularly for low-income families. In addition, once the premium is paid, other cost sharing, including deductibles and copayments, may make the insurance offered through the employer unattractive.

Eligibility for employer-sponsored health insurance does not preclude eligibility for public programs. When a low-income person eligible for public health assistance through MassHealth or the UCP is offered health insurance by their employer, s/he often must choose between that coverage and the public program. However, MassHealth, through its premium assistance programs, strives to enroll people in their employer-sponsored plans and wraps coverage around such plans for those who are eligible. These premium assistance programs encourage take-up of employer-sponsored health insurance and represent a partnership between private insurance and public coverage. Approximately 30,000 people are enrolled in a premium assistance program through MassHealth.

III. METHODS

This section describes the methods used by the DHCFP, working with staff from the Office of Medicaid, in approaching this analysis. Agency staff considered the available databases and what analyses were feasible given time and resource constraints. Some of the requested information was not available in either database and some information was available in one but not the other. The reader should carefully review both this section and the Limitations section (below) in order to fully understand the data presented in this report.

Time Period

The information in this report uses the following time periods for data analysis: PFY03 (Uncompensated Care Pool Fiscal Year 2003 which covers the period from October 1, 2002 through September 30, 2003) for UCP claims, and Massachusetts Fiscal Year 2004 (July 1, 2003 through June 30, 2004) for MassHealth claims.

Merging Files

Employers were grouped according to the number of employees using public health assistance during the time period examined. Employers with 50 or more employees using public health assistance were marked for inclusion in this report. One consequence of merging the files from two discrete databases is that people who had claims billed to both the UCP and MassHealth for the time period examined would have been counted twice in reaching the 50-person threshold for inclusion. While this was probably infrequent, it is important to note that the charges for such people were not counted twice. The Limitations section describes other instances in which merging MassHealth and UCP files qualifies the results.

Public Health Assistance Beneficiaries

Public health assistance beneficiaries' data were included in this report if the program (either UCP or MassHealth) was the primary payer of their health services; DHCFP examined only UCP claims for which the UCP was the primary payer. Similarly, MassHealth members enrolled in a premium assistance program were not included in this report. MassHealth members who have other insurance and whose claims are subject to third party liability payments (Medicare etc.) are likewise not included in this report.

MassHealth members enrolled in any of the four HMOs available to them were not included in this analysis. Their data resides in a separate database. Future reports will include these data.

The UCP claims database does not identify dependents separately, but the MassHealth database does, and these differences are reflected in the attached list of employers.

Employer Information

The DHCFP, through its UCP claims process, requests information on each user's employer. Since the data filed is not a required field, only 23% of UCP claims include a valid employer.

There were numerous variations on the spellings of what were obviously the same employers. DHCFP attempted to group employers that appeared to be the same employer. It is possible that some employers were grouped that should not have been, but it is not likely to have occurred often as care was used in grouping names of employers to allow for the possibility that two or more companies could have similar names. Two agency staff members checked each other's work to ensure the same decision would have been made by both of them.

Many UCP users reported being employed and reported their employer as babysitter, homemaker, student, etc. These "employers" were considered invalid for purposes of this analysis and were not included.

The MassHealth database contained more accurate employer addresses than the UCP database. Thus, employers that were in both the UCP and MassHealth databases were assigned the addresses from the MassHealth database. Given numerous spellings for the same street address, the city/town where the employer is located was chosen over the exact address. In instances in which different MassHealth members reported different addresses for the same employer name, employers were considered to have "multiple locations."

The Office of Medicaid maintains a database for its premium assistance programs that tracks information about health insurance at many Massachusetts employers. This extensive file includes information regarding whether an employer offers health insurance and the employers' and employees' contributions towards the premiums. This file contained much of the information needed for most of the employers who employ 50 or more public health beneficiaries.

The DHCFP called a sample group of employers from the premium assistance database to verify the information in the database. However, due to time constraints, staff did not verify much of the information. In addition, DHCFP staff called the employers that were not included in the database to determine if those employers offered health insurance to their employees and if so, the employers' percent contribution to their employees' premiums. DHCFP staff were unable to reach all employers in the given timeframe, and thus, some information on offer status and percent of contribution is missing from the attached list of employers.

Costs of Care

Approximately 77% of UCP users did not identify a valid employer, and therefore the costs associated with those users were not apportioned to an employer. For those UCP users who reported working for more than one employer, the costs of UCP care was apportioned equally among the valid employers that were reported by the UCP user. For example, if an UCP claim noted three employers, each employer would be assigned 33% of that UCP claim costs. If an UCP claim indicated that the patient worked for two "employers," one of which was not valid, the valid employer would be assigned all of the costs for that claim.

The costs associated with dependents of employees who were MassHealth members were identified separately in the MassHealth database and thus are reported separately per the legislation. Unfortunately, we were unable to distinguish the costs of employees from their dependents using the UCP database, thus employee and dependent costs are combined for UCP users.

Massachusetts costs for UCP users were calculated by multiplying the dollars each provider charged the UCP by the respective providers' cost to charge ratios. Readers should note that not all of these costs were reimbursed by the UCP.

IV. LIMITATIONS

There are a number of limitations with this analysis, some of which were mentioned earlier. One limitation of the data is that the employer data are self-reported; this is a problem with the UCP data in particular. Some of these limitations are attributable to inconsistency among hospital data collection. A few hospitals did not provide the name of an employer for any of their UCP claims.

Approximately 77% of UCP users do not provide the name of a "valid" employer. However, the DHCFP's 2004 uninsured survey indicates that sixty-eight percent of the uninsured are employed, with over two-thirds of the working uninsured working full-time. Therefore, the numbers of employers that meet the criteria for inclusion in this report and their associated public health care costs are assumed to be greater than the numbers reported here. In addition, all employers who have fewer than 50 employees using public assistance are excluded from this report. There were likely many employers not meeting the cut-off who also had employees and their dependents using public health assistance programs.

Another limitation with the data is that the MassHealth eligibility process "locks in" a member's employer to the database at the time of application. It is quite possible that some MassHealth members changed employers over the course of the year following enrollment but that would not be indicated on the database. Although the UCP claims database is more dynamic, the employer field is not required on UCP claims and thus UCP information has significantly more data missing from it.

Finally, it was difficult to identify unique employers within these databases, especially with respect to their ownership status and their provision of benefits. Chain stores that are franchises and independently owned, such as Dunkin Donuts stores and some fast food restaurants, are reported together as one employer with multiple sites even though many of the individual "stores" are independently owned. We do not know whether decisions regarding the provision of benefits are made at the local franchise level or at a corporate level. Furthermore, poor documentation of employers' addresses, particularly for UCP users, hindered our ability to separate franchises/chains that share the same name. Even if good quality information on location were available, it would be difficult to accurately group employers.

V. RESULTS

The attached list of employers provides information on those employers who have 50 or more employees receiving public health assistance during the time periods

specified in the Methods section. According to our analysis, most firms on this list offer health insurance to their employees and contribute an average of 70% towards the premium.

The attached list of employers contains the following information per employer: employer name, employer location, number of MassHealth members employed, costs of care provided to MassHealth members employed, number of UCP users employed, costs of care provided to UCP users employed and their dependents, number of dependents of employees enrolled in MassHealth, costs of care provided to MassHealth member dependents, total public health beneficiary count per employer, total cost of care, and percent contribution from employer towards insurance premium.

The total cost of care for these employees and their dependents was $52,595,881.

There are a number of problems with this analysis. Already mentioned are the data limitations including extensive missing data, inconsistent provider reporting, and the difficulties inherent in merging multiple discrete data files. Some of these issues can and will be resolved once the virtual gateway eligibility system is fully operational.

Perhaps a larger, more fundamental problem with this analysis is that these data, even if complete, do not take into consideration the complex decision-making involved at the employer and employee level. Since we do not have information on whether these particular employees are eligible for the health insurance offered by their employer, it is difficult to ascribe blame or to develop actionable steps. For instance, if an employer offers a generous package but the package has high copayments or deductibles or limits services, the eligible employee may make a rational decision to enroll in the MassHealth program, if eligible. A low-income, MassHealth-eligible employee may even prefer to go without health insurance and seek care through the UCP. If employees are not eligible for their employer-sponsored health insurance, it could be due to the waiting periods, part-time work status, or other factors, which may be beyond the control of the employee.

Many health care coverage decisions are complex and multifaceted. For low-income people, a major factor is almost always cost. Health insurance is expensive and becoming more so. Although the policies and programs currently in place in Massachusetts provide a very important safety net for many low-income people, it should also be recognized that such programs provide incentives, for both employers and employees, to shift health care costs to the public sector.